Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CARRIER ASSIGNMENT OF MEDICARE PROVIDER NUMBERS

Richard P. Kusserow
INSPECTOR GENERAL

APRIL 1992

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services' (HHS) programs as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by three OIG operating components: the Office of Audit Services, the Office of Investigations, and the Office of Evaluation and Inspections. The OIG also informs the Secretary of HHS of program and management problems, and recommends courses to correct them.

OFFICE OF AUDIT SERVICES

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities, and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse and mismanagement and to promote economy and efficiency throughout the Department.

OFFICE OF INVESTIGATIONS

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil money penalties. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

OFFICE OF EVALUATION AND INSPECTIONS

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

Entitled "Carrier Assignment of Medicare Provider Numbers," this report describes and assesses the process by which Medicare carriers assign provider numbers. This report was prepared under the direction of Ralph Tunnell, Regional Inspector General of Region VI, Office of Evaluation and Inspections, and Chester B. Slaughter, Deputy Regional Inspector General. Participating in this project were the following OIG personnel:

Region VI, OEI

Kevin Golladay
Leah Bostick
Douglas Lauver

Headquarters, OEI

Wayne Powell

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CARRIER ASSIGNMENT OF MEDICARE PROVIDER NUMBERS

Richard P. Kusserow
INSPECTOR GENERAL

OEI-O6-89-00871

EXECUTIVE SUMMARY

PURPOSE

This report describes and assesses the process by which Medicare carriers assign provider numbers.

BACKGROUND

Medicare carriers assign provider numbers to qualified providers of Part B services who furnish services or supplies to Medicare beneficiaries. The numbers are used in processing claims and establishing Medicare pricing and utilization profiles. To obtain a provider number from a carrier, providers typically complete the carrier's provider number application form and meet criteria specified by Medicare regulations. Carriers are responsible for determining if providers meet Medicare criteria through its number assignment process.

METHODOLOGY

This inspection consisted of several phases. First, we conducted a review of relevant Health Care Financing Administration (HCFA) policies and Medicare laws and discussions with HCFA staff. Next, we requested copies of all application forms used by carriers to obtain information prior to assigning a number to a provider. To test assignment procedures, we reviewed carrier documentation supporting the recent assignment of numbers to more than 240 providers. Specifically, 40 carriers were asked to supply file documentation for the most recent applicant assigned a provider number for seven different types of providers (solo physician, physician group or clinic, chiropractor, durable medical equipment supplier, ambulance, certified registered nurse anesthetist, and physician assistant). Next, we surveyed 38 carrier personnel responsible for assigning numbers. Additionally, we discussed provider number assignment vulnerabilities with carrier program integrity staff (25 respondents) and reviewed files of providers with overpayments selected from the 12/01/89 HCFA Physician/Supplier Overpayment Report. Finally, we reviewed Management Implication Reports (MIRs) prepared by the Office of Inspector General's Office of Investigations (OI) suggesting provider number assignment problems and concerns. We contacted each of the eight OI regional offices to obtain case experience and perspectives and to discuss prior MIRs.

FINDINGS

HCFA's Direction and Oversight of Carrier Provider Number Assignment Procedures are Inadequate.

The HCFA provides insufficient practical direction to carriers concerning the provider number assignment function. Specifically, HCFA has not clearly defined the methods or depth of understanding and testing to ensure adequate knowledge about a provider before a number is assigned. Our review of carrier instructions in the Medicare

Carrier Manual (MCM) identified several issues not adequately addressed. For example, what is a carrier's responsibility to understand and determine legal authorization to practice? This lack of direction and oversight contributes to carrier provider number assignment weaknesses and vulnerabilities.

Carrier Provider Number Assignment Weaknesses and Vulnerabilities Exist.

- ***Many carriers do not adequately document provider number assignment procedures.***

- ***Carriers obtain or maintain too little provider information.***

  - Application forms often do not obtain sufficient information from providers.

  - Little or no business ownership information is required by carriers.

  - Ironically, the least regulated providers (e.g., durable medical equipment) are the least scrutinized by carriers when applying for a provider number.

  - Carrier application forms are often missing or not readily retrievable.

- ***Some carriers fail to verify provider qualifications prior to assignment of a provider number.***

  - Some carriers do not validate provider credentials (e.g., State license).

  - Many carriers allow reassignment of benefits without determining if the reassignment meets Medicare legal requirements.

- ***Weak provider number assignment procedures contribute to program vulnerabilities.***

  - Carrier methods or practice to identify all numbers assigned to a provider are inadequate.

  - Providers can manipulate multiple numbers and jurisdiction rules to increase reimbursement or avoid detection of abusive practices.

  - Most carriers do not uniquely identify physician assistants and thus, cannot perform adequate utilization review.

  - Carrier computer records maintained on providers need improvement. Specifically, provider name irregularities exist and provider State license numbers are missing or inaccurately entered.

- ***Many carriers assign additional provider numbers solely for a provider's bookkeeping convenience.***

OIG Recommendations and HCFA Action Plan

In our draft report, we made specific recommendations to correct the weaknesses cited above. (They are included verbatim on page 20 of this final report.) The HCFA provided written comments on the draft report. More importantly, however, HCFA itself has undertaken several major initiatives to address these problems and related issues raised in a prior OIG report entitled "Carrier Maintenance of Medicare Provider Numbers." We and HCFA, therefore, worked together to reach agreement on an action plan to improve the provider number process. In light of this, we are no longer designating the problems cited in this and the prior report as a material weakness. The following is the agreed upon action plan:

MEDICARE PROVIDER NUMBERS

ACTION PLAN

GENERAL

HCFA will issue a modification to the Medicare Carrier Manual which will:

Clearly state that carriers have a responsibility to ensure the integrity of provider numbers and to ensure that only those practitioners and providers with legal authority to practice are given and may retain provider numbers.

Require carriers to stay abreast of changes in relevant laws and regulations concerning medical practice requirements.

Require carriers to make every reasonable effort to receive on an ongoing basis information from State licensing authorities and other appropriate bodies about the currency of licenses.

Require carriers to maintain provider number applications for at least six years after deactivation of the number (the period needed to facilitate investigations, prosecutions, and sanctions). This requirement pertains to applications from both health professionals and provider entities which are discussed separately below.

Require carriers to periodically purge from their lists of approved numbers those that have been inactive and for professionals or entities who no longer have valid licenses required by the State.

HEALTH PROFESSIONALS

HCFA will continue to vigorously implement and enforce compliance with the provisions of the recently established UPIN system for Medicare physicians

(which includes medical doctors, osteopaths, dentists, chiropractors, podiatrists, and optometrists).

HCFA will explore the extension of the UPIN system to cover all limited licensed professionals that can bill Medicare directly. HCFA will provide a schedule for doing so. This would include clinical psychologists, clinical social workers, and certified registered nurse anesthetists.

All registry data will be made readily available to all carriers on January 1. 1992. (Procedures prior to that date only allowed carriers to obtain information about professionals within their own jurisdiction.)

HCFA will monitor and ensure compliance of the carriers with their responsibilities regarding provider numbers as set forth in the Medicare Carrier Manual. (See *GENERAL* section above.)

SUPPLIERS

HCFA will implement a major reform of the carrier process for dealing with certain "suppliers". (Here, the term is meant to include entities which provide: durable medical equipment, routine and readily available supplies, prosthetics, orthotics, immunosuppressant drugs, and ESRD services.)

Some of the more important features of this initiative are:

> Four regional carriers will be responsible for establishing supplier numbers and processing all Medicare claims for the above mentioned supplies.
>
> A clearinghouse which will contain information from supplier number applications and whose data will be accessible to all of these carriers.
>
> A standard application form which includes information to enable the carriers to identify each unique entity, their ownership, related entities, and sanctions.
>
> The application form will contain a signed statement of the applicant attesting to the veracity of all information provided and acknowledging responsibility for false or misleading statements.
>
> The carriers will be responsible for processing all claims for supplies furnished to beneficiaries who reside within their jurisdiction.

HCFA plans to implement this major reform within the next two years.

The statement of work for the contract under which these carriers will function will include a clear statement of responsibilities concerning supplier numbers similar to those listed in the *GENERAL* section above.

These carriers will be required to use the information in the clearinghouse to screen applicants for supplier numbers for such things as relationships to sanctioned individuals or business or to businesses suspected of fraud or abuse.

The carriers will verify the accuracy and completeness of the information contained in supplier number applications and files, and will identify and take appropriate action against problem suppliers.

HCFA will vigorously monitor compliance of these carriers with those contractual provisions related to the application for, granting of, and maintenance of supplier numbers. HCFA is determining how the performance of these carriers will be evaluated.

HCFA will require carriers to reenroll all suppliers every two years to insure that the ownership and operating information remains current.

In the future, HCFA will extend this system to cover other supplier entities such as independent physiological labs, magnetic resonance imagers, and ambulance companies. In the meantime, however, these other supplier entities will be required to use a standard application form with provisions for identifying ownership and sanctions, and including the signed veracity certification.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

INTRODUCTION 1

Purpose. 1
Background. 1
Methodology. 4

FINDINGS 6

HCFA's Direction and Oversight of Carrier Provider Number Assignment Procedures are Inadequate 6

Carrier Provider Number Assignment Weaknesses and Vulnerabilities Exist 7

Many carriers do not document provider number assignment procedures 7

Carriers obtain or maintain too little provider information 7

Some carriers fail to verify provider qualifications 10

Weak provider number assignment procedures contribute to program vulnerabilities 12

Many carriers assign additional provider numbers solely for a provider's bookkeeping convenience 17

RECOMMENDATIONS 20

HCFA RESPONSE AND ACTION PLAN 22

APPENDICES 24

Appendix A:	Part B Providers
Appendix B:	Carrier Respondents and State Jurisdictions
Appendix C:	Examples of Information Requested on Application Forms for DME and Physicians
Appendix D:	Claim Jurisdiction Rules Simplified
Appendix E:	Examples of Carrier Methods of Processing PA Claims
Appendix F:	Physician Registry Activity by Carrier
Appendix G:	Carrier Provider Number Assignment Activity
Appendix H:	Carrier Supplied Counts of Various Types of Providers

INTRODUCTION

PURPOSE

This report reviews the process by which Medicare carriers assign provider numbers. Specific objectives were to:

1) describe and assess carrier provider number assignment procedures and
2) discuss vulnerabilities in these procedures.

A recently released report, "Carrier Maintenance of Medicare Provider Numbers" (OEI-06-89-00870), prepared in conjunction with this inspection, describes and assesses how carriers maintain provider numbers once assigned.

BACKGROUND

Carriers are private insurance companies acting under contract with the Health Care Financing Administration (HCFA) to process claims by beneficiaries and providers for services or supplies covered under Medicare Part B. While most States have jurisdiction for one State, a few carriers handle more than one State. The HCFA provides direction to the carriers on payment matters and is ultimately responsible for ensuring carriers adhere to applicable program policies and procedures.

In fiscal year 1989, Part B covered approximately 32 million enrollees and paid benefits of about $37 billion for over 407 million claims. With such an enormous expenditure of government funds and volume of claims to process, it is imperative carriers ensure payments are 1) made only for services covered under the Medicare program, 2) medically necessary under recognized standards of medical care, 3) actually rendered to eligible Medicare beneficiaries, 4) reimbursed at appropriate payment levels, and 5) delivered by providers meeting standards required by State and Federal law.

State Licensure and Certification

Licensing and certifying providers are primarily State functions. Individuals or entities must meet State criteria to obtain and maintain a license or certification. The States are responsible for regulating the practice of those they have licensed or certified. States are also responsible for ensuring these providers meet standards of professional competence and personal integrity considered necessary to protect the public.

The State license or certificate demonstrates the provider satisfies the State's established standards in such areas as education, experience, and ethics. Once licensed or certified, the provider must then comply with the State's prescribed standards for the practice of the profession and any other specified criteria for maintaining a license or certification.

Failure to meet these requirements may result in the State suspending or restricting the license or certificate to provide services. When a provider loses the legal authority to practice, no services of the provider are covered by Medicare.

Federal Interest in Medical Provider Qualifications

The Federal government has shown a strong interest in ensuring medical providers have adequate qualifications. The Consolidated Omnibus Budget Reconciliation Act of 1985 mandated a physician registry and the use of a unique practitioner identifier number (UPIN) to prevent duplicate payments for hospital-based physicians and interns under the Medicare program and to more accurately track Federally-sanctioned physicians. The HCFA oversees the registry.

Another database, the National Practitioner Data Bank, recently began operation monitoring State licensed health practitioners. This data bank maintains records of all adverse actions (e.g., license revocation, malpractice) taken against medical providers and entities after the opening of the data bank. The data bank was authorized by the Health Care Quality Improvement Act of 1986 (P.L. 99-660, title IV) and the Medicare and Medicaid Patient and Program Protection Act of 1987 (P.L. 100-93, section 5). This databank is monitored by the Public Health Service (PHS).

These two databases enhance the Federal government's ability to monitor providers. However, responsibility for ensuring Medicare providers meet licensing and other requirements specified by State and Federal law rests ultimately with carriers.

Carrier Provider Number Assignment

Carriers assign unique identification numbers (hereafter referred to as provider numbers) to providers of Medicare Part B reimbursable services or supplies. Provider numbers are used in processing claims for services rendered to Medicare beneficiaries. The number is also used in establishing Medicare pricing and utilization profiles. If the provider of services does not have a provider number, payment probably will not be made for services. To obtain a provider number from a carrier, providers must follow the carrier's application procedures. This generally involves completion of the carrier's provider number application form. Additionally, the provider must meet Medicare requirements. Carriers assume all costs for assigning and maintaining provider numbers.

The accuracy and effectiveness of a carrier in meeting applicable Medicare responsibilities is dependent in large measure upon its *provider number assignment process*. As described thus far, the provider number assignment process appears to be relatively simple. However, its simplicity disguises its importance; failure to adequately determine a provider's qualifications and payment variables can have significant consequences for the Medicare program in fraud, abuse, or error. Prudence and common sense dictate provider numbers should be guarded with every reasonable diligence.

Medicare Requirements

Prior to the issuance of a provider number, carriers need to establish the following:

Provider Identification	What provider(s) renders services or supplies?
Credential Verification	Does the provider meet Medicare qualifications (e.g., legally authorized by the State where services are rendered)?
Exclusion from Participation	Is the provider prohibited from participating in the Medicare program?
Carrier Claim Jurisdiction	What carrier has jurisdiction for claims submitted by the provider?
Carrier Pricing Rules	What method of reimbursement applies (e.g., fee schedule)? What is the correct customary and prevailing charge to use? What is the specialty of the provider? Is the provider Medicare participating or not?
Reassignment Limitations	Will the payment go to the provider of services or to another (e.g., employer)? If so, will the recipient of monies meet Medicare reassignment limitations?
Reporting Requirements	What information is required for submission of a record by carriers to the Physician Registry and to HCFA?
Utilization Review	What review and profiling parameters should apply to this provider?

Further, Medicare law and policy differentiates between two very different types of applicants for Medicare provider numbers:

- **Providers of services or supplies** - entities and individuals actually performing services or providing supplies to beneficiaries.

  Carriers are responsible for verification of any prerequisite credentials (e.g., license, equipment, seller's permit, etc.) specified by State, local, or Federal law. Medicare law and policy place differing requirements on different types of providers. Generally, a provider of services must be legally authorized to provide the services by the State where services are rendered. For example, Medicare law requires covered physician services be rendered by licensed physicians who are "legally authorized to practice" (Social Security Act, Section 1861) by the State where the services are rendered.

  Although qualifications for other Medicare provider types may include State licensure or certification, some providers (e.g., ambulance companies) are required to meet additional education, work experience, staff, or equipment needs in order to participate in the Medicare program.

However, this is not to say every provider type must meet specified criteria. Some providers, such as durable medical equipment (DME), generally[1] do not have to meet any criteria except to possess a Social Security number or an employer identification number.

Beyond the need to determine applicant qualifications, there are a variety of payment and program integrity responsibilities tied to data collection and computer analysis of the service provider's Medicare experience.

- **Billers of services and supplies** - entities and organizations billing for the services or supplies provided.

  Carriers must determine if the entity requesting payment meets Medicare requirements. If the individual or entity (partnership, professional association, clinic, etc.) billing and receiving payment did not actually provide the service or supply, carriers must establish the relationship between the biller and performer of services. Also, Medicare requires carriers to ensure payment is not made to entities or individuals excluded from participation in Medicare. Finally, carriers should have sufficient information about the billing entity (owners, agents, officers, etc.) in the event questions arise concerning payment or if overpayments need to be recovered from liable individuals or entities.

In addition to the concern over provider number assignment, the areas addressed in this report are considered especially timely in light of physician payment reforms, establishment of the Physician Registry, and HCFA's interest in ensuring the quality of providers of Medicare services.

METHODOLOGY

This inspection consisted of several phases. First, we conducted a review of relevant HCFA policies and Medicare laws and discussions with HCFA staff. Next, we requested copies of all application forms used by carriers to obtain information prior to assigning a number to a provider. To test assignment procedures, we reviewed carrier documentation supporting the recent assignment of numbers to more than 240 providers. Specifically, 40 carriers were asked to supply file documentation for the most recent applicant assigned a provider number in the following categories:

- Solo-practice physician
- Physician group or clinic
- Chiropractor
- Ambulance
- Durable medical equipment
- Physician assistant (PA)
- Certified registered nurse anesthetist (CRNA)

For this inspection, we excluded any review of providers certified by HCFA for participation in Medicare. This was done to limit the scope of work. Additionally,

this was done in recognition of State survey and certification agency review of the provider's credentials and HCFA's assignment of provider numbers rather than carrier assignment of provider numbers to many of these types of providers. (See Appendix A for a list of Part B providers and those certified by HCFA.)

Next, we visited three carriers and mailed surveys, with telephone followup, to 35 others. (See Appendix B for a complete list of carrier respondents and State jurisdictions.) The 38 respondents were carrier personnel responsible for assigning numbers.

Additionally, we discussed number assignment vulnerabilities with carrier program integrity staff (25 respondents) and reviewed files of providers with overpayments selected from the 12/01/89 HCFA Physician/Supplier Overpayment Report.

Finally, we reviewed Management Implication Reports (MIRs) prepared by the Office of Inspector General's Office of Investigations (OI) suggesting provider number assignment problems and concerns. We contacted the eight OI regional offices to obtain case experience and perspectives and to discuss prior MIRs.

FINDINGS

HCFA's Direction and Oversight of Carrier Provider Number Assignment Procedures are Inadequate.

The HCFA provides insufficient practical direction to carriers concerning the provider number assignment function. Specifically, HCFA has not clearly defined the methods or depth of understanding and testing to insure adequate knowledge about a provider before a number is assigned (e.g., DME). Our review of carrier instructions in the Medicare Carrier Manual (MCM) identified several issues not adequately addressed. Among them are:

How are carriers to determine legal authorization to practice?

What is the minimum information to be obtained from providers by carriers?

What identifying provider information should be maintained in the carrier's computer system?

How is a physician's specialty to be determined?

Should providers complete carrier application forms? Should they be maintained?

When is it appropriate to assign multiple provider numbers to the same provider?

What carrier controls should exist for the utilization review of providers having multiple numbers?

Insufficient direction and oversight has contributed to carrier assignment vulnerabilities. Twenty of the carrier provider number assignment personnel contacted recognize weaknesses and believe HCFA should play a prominent role by providing more guidance concerning number assignment policies. Some areas noted by carriers include the need for:

More "policy issued regarding suppliers - establishing guidelines for qualifying as a DME supplier, ownership questions, etc."

More specific guidance on "jurisdiction, multiple office settings, and clinics."

"National standards for non-physicians (e.g., DME)."

"Clearer guidelines regarding physicians under contract with groups/clinics and other physicians meeting employee status requirements."

"Certification guidelines for physiological laboratories."

"Guidance when it is appropriate to have more than one number."

A critical and fundamental point of control for correct payment and detection of abusive providers occurs during the provider number assignment process. While the Physician Registry is certainly a step in the right direction, many weaknesses and vulnerabilities still exist in provider number assignment procedures. These weaknesses or vulnerabilities could result in adverse monetary or quality of care consequences for the Medicare program or beneficiaries.

Carrier Provider Number Assignment Weaknesses and Vulnerabilities Exist.

Many carriers do not adequately document provider number assignment procedures.

Nearly 50 percent of carriers (18) have no formal written internal procedures for number assignment. A lack of written instructions on provider number assignment may complicate training of new staff and may promote inconsistency in the provider number assignment process. Additionally, a lack of documented procedures may complicate review by HCFA to determine carrier implementation of manual instructions affecting provider number assignment.

Carriers obtain or maintain too little provider information.

- Application forms often do not obtain sufficient information from providers.

Carrier applications represent the minimal information required to determine who the provider is and what pricing parameters apply (locality, specialty, hospital based, etc.). The applications used by carriers raise concern about the rigor with which carriers scrutinize providers. This concern is based on the fact that many carrier provider number application forms obtain little information from provider number applicants. (See Appendix C for a listing of the types of questions being asked on application forms for DME and physicians).

Many carriers limit applications to a few basic claims questions (name, tax number, address, type of provider, and license number); few ask for additional information. (See Figure 1 for examples of questions asked by carriers.) By not asking questions beyond basic claims information, a carrier may make incorrect assumptions about the provider's situation.

Additionally, several carrier application forms lack professionalism. Specifically, the application form may not be professional in appearance (i.e., typeset or desktop published). Also, questions may not be 1) presented in a logical sequence or 2) clear in meaning.

Carriers Require Little Information From Providers

Physician — Information Requested	Carriers Gathering Data Count	Percent
Basic Information: name, address, phone #, tax #, specialty, and UPIN data?	38	100%
Board certified?	35	92%
Any licenses in any other States?	6	16%
What type of practice (group, solo, etc.)?	29	76%
Do you have any other practice addresses?	11	29%
Are you hospital based or compensated?	13	34%
Are you a resident or an intern?	27	71%
Do you use a billing agency?	6	16%
What other provider numbers with this carrier do you have?	15	39%
What other provider numbers with other carriers do you have?	18	47%
Do you employ a PA or a nurse practitioner?	1	3%
Do you provide services in a Health Manpower Shortage Area?	7	18%
Have you ever been subject to sanctionable actions?	3	8%
Application must be signed.	34	89%
To be signed by physician.	12	32%
To be signed by applicant or representative.	6	16%
Not specified who must sign.	16	42%
Application includes a certification statement attesting to truthfulness.	13	34%
Durable Medical Equipment Supplier		
Basic Information: business name, address, phone #, and tax #?	37	100%
Requires or requests some type of documentation with application. (e.g., articles of incorporation, seller's permit, references, etc.)	10	27%
Application include a certification statement attesting to truthfulness.	7	19%
Application must be signed.	34	92%
Title of person signing application?	15	41%
Date of application completion by applicant?	26	70%
Type of business (individual, partnership, corporation, etc.)?	7	19%
Have owners or employees been subject to sanctionable actions?	1	3%
Questions concerning how supplies are delivered, marketed, etc.	8	22%
Do you use a billing service?	6	16%
Will you be billing for patients located in other states?	3	8%
Owner's name?	22	59%
List of all licensed practitioners who are employees or have financial interest?	3	8%
Any other numbers with this carrier?	5	14%
Any other provider numbers in other carrier jurisdictions?	9	24%
Any other satellite offices/locations in the State?	13	35%
Do owners or operators have any other provider numbers?	2	5%
Do you have sales representatives in this State?	12	32%
Date this business started or began providing services?	12	32%

Source: Review of application forms provided by carriers (37 for DME and 38 for physicians)

Figure 1

- Little or no business ownership information is required by carriers.

Over one-third of carriers reviewed (15) do not routinely ask for DME ownership information on the application for assignment of a provider number. A slightly higher number (22) of carriers do not routinely ask ambulance companies to identify owners. Only one carrier requires ownership information from clinics or professional associations.

A lack of ownership information leaves the carrier in a position of not being able to determine if the company is controlled or owned by an individual, group of individuals, or a

business entity who has been convicted of a criminal or sanctionable offense related to participation in Medicare and Medicaid.

Also, failure to obtain ownership allows providers the opportunity to escape carrier review of provider numbers not identified with the owner(s). For example, 12 carriers noted instances during the past year where business entities with overpayments or who were on prepayment or postpayment review simply ceased using the provider number for the troubled business and obtained a new provider number from the same or other carriers. Some providers may even use the same employer identification number (EIN), social security number (SSN), or address but simply change their name on the new application for a new provider number. Without ownership information, alteration of any identifying information (name, EIN, address) can disguise the provider enough to obtain a new provider number. Thus, a provider may easily escape carrier controls.

Even when ownership information is required, many carriers limit ownership questions to a single owner's name. Very few carriers require the supplier to identify all owners, individuals with financial interest, directors, and/or officers.

Carriers have long been criticized for not requiring businesses to disclose ownership. In response to this weakness, Congress has passed legislation (Omnibus Budget Reconciliation Act of 1990, P.L. 101-508) providing the authority for carriers to obtain ownership and financial interest information from suppliers and mobile labs. Although implementing regulations are not yet written by HCFA, ownership information should enhance carrier efforts to track problem suppliers. However, carriers must be required to obtain and use ownership information if the gathering of such information is to have a real impact on deterring fraud and abuse.

- Ironically, the least regulated providers are the least scrutinized by carriers when applying for a provider number.

Some nonphysician suppliers are essentially unregulated by State and Federal agencies. These entities provide such products as DME, oxygen[2], prosthetics, and other similar types of supplies. The HCFA does not require carriers to obtain specific information from these providers. As a consequence, only a few carriers ask for additional application information beyond basic information (e.g., name, address, tax number, phone number) to ensure a carrier's understanding of the provider's request and situation. Additional information may be needed to correctly determine payment or utilization review parameters.

Some areas not fully explored by all carriers involve ownership, carrier jurisdiction, and the provider's present and past Medicare activity. Such information is crucial as a first step in deterring providers from "gaming" the program (a provider's efforts to maximize reimbursement through fraudulent or abusive practices).

- Carrier application forms are often missing or not readily retrievable.

While few (5) carriers reported not requiring completed applications prior to provider number assignment, many carriers requiring completed applications do not have applications

(hardcopy or microfiche) for many active providers. For example, Aetna of Georgia estimates only 20 percent of providers have applications on file. The carrier reports, during the transition from the prior carrier to Aetna (1989), files were "received incomplete." Equicor (North Carolina) estimates from 15 to 20 percent of applications are missing. Like Aetna, Equicor attributes this to the previous carrier which did not always require completed applications. Another carrier, Blue Cross and Blue Shield of Alabama, estimates 15 to 25 percent of applications are missing because the carrier's "application process has been in place for only 3 years."

The application document acts as a source record if any questions arise concerning possible misrepresentation on the part of the provider. According to OI investigators and HCFA, such a record is often very important to criminal cases and civil recovery by the carrier and HCFA.

Additionally, in our review of documentation supporting providers recently assigned provider numbers, we found some key documentation was lacking. For example, the carrier may have reported verification of the provider's license was done by requesting a copy of the license from the provider; however, no license was present in the file documentation. Additionally, if telephone contact with the licensing board was made, most carriers failed to document the call. Our review of documentation for physicians recently assigned a provider number, revealed only 19 carriers had adequately documented their method of licensure verification.

Some carriers fail to verify provider qualifications prior to assignment of a provider number.

- Some carriers do not validate provider credentials.

Several carriers do not validate or document the credentials of Part B providers prior to provider number assignment. (See Figure 2.) In direct contradiction to Part 4 of the MCM, six carriers make no attempt to validate a solo practice physician's license. The MCM (1001.3) specifically states, at a minimum, carriers will "verify all physician submitted data with the appropriate State licensing board to determine if the physician is registered and licensed to practice." An additional three carriers do not validate credentials of a physician in a group or clinic. Again, these carriers are not in compliance with MCM instructions which specifically require credential verification "regardless of whether the physician has a solo or group practice."

Carriers report validation is not done primarily because of a lack of resources or funding for this activity. None of the carriers attributed their failure to validate a medical physician's license to lack of cooperativeness by the applicable State medical board. During our discussions with these State medical boards, each reported it could and would respond in a timely manner to carrier attempts to verify a license.

The MCM does not specify the methods by which carriers must verify provider credentials. As a consequence, the methods used differ between carriers. Most carriers verify a provider's license and registration from a board listing of licensed providers. Other carriers

either contact boards directly or request a copy of the license or registration from the provider. (See Figure 2.)

Provider	ROUTINE METHOD OF CREDENTIAL VERIFICATION									
	No Verification		Copy of License/Certification		Contacted Board		Checked Listing		HCFA Cert. Letter	
Medical Physician	6	16%	4	11%	7	19%	20	54%		0%
Osteopathic Physician	7	19%	4	11%	9	24%	17	46%		0%
Physician Assistant*	11	30%	11	30%	7	19%	8	22%		0%
Dentist	8	22%	6	16%	10	27%	13	35%		0%
Chiropractor	6	16%	5	14%	9	24%	13	35%	4	11%
Psychologist	6	16%	5	14%	9	24%	17	46%		0%
Optometrist	7	19%	8	22%	10	27%	12	32%		0%
Podiatrist	6	16%	6	16%	10	27%	15	41%		0%
CRNA	2	5%	9	24%	9	24%	17	46%		0%

** Two carriers required no verification since State does not recognize PAs* *Source: Carrier Survey (37 respondents)*

Figure 2

The MCM (2070.2) requires carriers to obtain listings from boards for some provider types. For example, carriers are required to "secure from the State licensing agency a current listing of psychologists holding the required credentials." We found several carriers not maintaining such a listing. They either contact the board for verification, accept a copy of the license from the provider, or do not validate the license. Further, the MCM does not specify how often the listing must be updated.

- Many carriers allow reassignment of benefits without determining if the reassignment meets Medicare legal requirements.

Carriers are limited by Medicare law in paying assigned benefits. Payment is made only to the physician or other supplier who furnished the service and may not be made to any other person or organization under a reassignment, or power of attorney, or under any other arrangement where the other person or organization receives the payment directly. Payment is considered to be made directly to an ineligible person or organization if the person or organization can convert the payment to its own use and control without the payment first passing through the control of the physician or other supplier or a party eligible to receive the payment under reassignment exceptions.[3] (See Figure 3.)

Reassignment Exceptions

1) **Payment to Employer** - The Medicare program may pay the employer of the physician or other supplier if the physician or other supplier is required, as a condition of his employment, to turn over to his employer the fees for this services.

2) **Payment to Facility** - The Medicare program may pay the facility in which the service was furnished if there is a contractual arrangement between the facility and the physician or other supplier under which the facility bills for the physician's or other supplier's service.

3) **Payment to Organized Health Care Delivery System** - The Medicare program may pay an organized health care delivery system if there is a contractual arrangement between the organization and the physician or other supplier under which the organization bills for the physician or other supplier's services.

4) **Payment to a Governmental Agency** - Medicare law does not preclude reassignment to a governmental agency or entity which qualifies for payment under 1, 2 or 3 above as an employer, facility, or organization.

5) **Payment Pursuant to a Court Order** - Payment may be made provided the conditions set forth in the Medicare Carriers Manual, Part II, 5304 are satisfied.

6) **Payment to an Agent** - The Medicare program may make payment in the name of the provider to an agent who furnishes billing or collection services for a provider or entity authorized to receive payment.

Figure 3

Although reassignment exceptions should be tested prior to the assignment of a provider number, many of the carrier application forms reviewed do not question the provider concerning which reassignment exceptions are met. Only 15 carrier application forms attempt to test the reassignment exception. For example, Texas Blue Cross and Blue Shield requests the applicant to specify if an employee-employer relationship exists. (A W-2 would indicate such a relationship, whereas a 1099 indicates a contractor relationship.)

Additionally, 11 carrier group/clinic application forms involving reassignment do not provide a signed acknowledgement of reassignment by group or clinic members.

Weak provider number assignment procedures contribute to program vulnerabilities.

- Carrier methods or practices to identify all provider numbers assigned to a provider are inadequate.

Carrier controls to identify all provider numbers assigned to the same entity are insufficient. Most carriers make little effort to link related provider numbers. Only five carriers link related provider numbers with a computer linking tag and only seven other carriers link provider numbers through their process of building off of a base number (modifiers added to

base number). These linking procedures make determination of a provider's numbers a relatively simple matter in most cases. However, in order for the linking process to be complete, the carrier must determine all provider numbers related to a provider at the time of provider number assignment.

Other carriers rely on manual and/or computer searching for related provider numbers for the same provider. Searching may be done by name, SSN or EIN, license number, ownership, UPIN, or address (or a combination of these). However, carriers typically do not employ all available search criteria to identify related provider numbers. Such limited searches allow for the possibility of missing a related provider number. For example, a name search on a business might not identify a supplier with several provider numbers under differing names (e.g., Allied Medical Supply, AMS, Allied Supply). Additionally, although the provider number department may routinely conduct adequate searches for provider numbers, other carrier departments (e.g., overpayment recovery, medical review) may not.

Requesting on the application all additional provider numbers the provider number applicant now has or has had with <u>any</u> carrier is a good practice. Many (24) carriers reported requiring providers to identify any other provider numbers issued by their carrier. However, only 12 carriers report asking for any numbers providers have with <u>other</u> carriers.

There was no indication in provider files reviewed of searches for additional provider numbers. Consequently, we have no documentation of the extent of review effort employed by carriers. We do know, from talking to carrier personnel, at least one carrier makes no effort to check for additional provider numbers, relying solely on the provider to list on the application any existing provider numbers.

- Providers can manipulate multiple provider numbers and jurisdiction rules to increase reimbursement or avoid detection of abusive practices.

Medicare utilizes a system of provider payment based on historical fee patterns and carriers' discretionary definitions of geographic pay localities, provider specialty, and other payment variables. This process results in payment differentials among types of procedures, carrier pricing localities, specialties, and sites of care. Additionally, differences exist in carrier UR policies. Combined, these factors create an environment where incentives exist for providers to misrepresent themselves or take advantage of regulatory or carrier loopholes in order to maximize reimbursement or avoid detection of abusive practices. Two areas especially vulnerable to abuse are manipulation of provider numbers to avoid program integrity review and manipulation of claim jurisdiction rules.

<u>Providers with multiple provider numbers can weaken a carrier's program integrity activities.</u>

Many of the program integrity staff interviewed report usage of multiple provider numbers make medical and utilization reviews (MR/UR) more difficult. A provider with multiple provider numbers can knowingly or unknowingly, evade some utilization screens (e.g., initial office visits) and possible prepayment or postpayment reviews if all of the provider's numbers are not identified for review and used in the review process.

One of the primary purposes of postpayment UR is to compare the pattern of practice of individual providers with that of their peers in several separate categories of services, such as office and hospital visits. This review involves the computer generation of the previous calendar year's paid claims data for all providers in the carrier's service area. Since the profiles make comparisons to other like providers and predefined limits, the failure of the carrier to assemble a provider's full service history through its computer could produce misleading results. Specifically, the UR report may not reveal an existing aberrant practice. For example, a provider with several provider numbers may spread billings among the provider numbers so that any one provider number will not exceed a UR screen threshold; yet, when combined, may exceed the threshold.

Complicating the adequacy of program integrity activity as well as provider number assignment may be a lack of knowledge of each department's concerns and activities. Only four carrier program integrity respondents stated they were more than somewhat familiar with assignment procedures. Additionally, nearly all program integrity respondents stated more information should be obtained from providers. However, provider assignment departments may not be informed of or respond to suggestions by program integrity staff. As one program integrity respondent stated, "they rarely utilize our suggestions for change."

A lack of communication and coordination may lesson the effectiveness of both program integrity functions and the adequacy of provider number assignment. Since each area may encounter different problems where improvements in the assignment process could alleviate, both should maintain close ties. Additionally, this should apply to other areas affected by provider number assignment policies (e.g., overpayment recovery).

Carrier provider number application inadequacies and weak guidelines allow manipulation and abuse of carrier claim jurisdiction.

Carrier claim jurisdiction issues, addressed in the MCM section 3100, apply to 1) a carrier's determination whether this or another carrier is responsible for processing the provider's claims and 2) what pricing locality within the carrier should be used. (See Appendix D for a simplified view of jurisdiction rules.)

Many carrier provider number applications do not ask sufficient questions to fully test jurisdiction rules. As an example, only 12 carriers determine through their application forms if durable medical equipment suppliers have sales representatives in the State. This is just one of many questions which could help a carrier determine proper claim jurisdiction. Failure to ask such questions could cause the carrier to make an incorrect claim jurisdiction decision which, in turn, could result in payments from carriers with higher reimbursement allowances or less stringent UR policies.

Carriers indicate concern some providers (e.g., DME) misrepresent themselves when obtaining provider numbers or manipulate the jurisdiction rules (e.g., point of sale through use of 1-800 numbers or call forwarding) in order to game the system. Specifically, some providers "forum shop" to find the carrier paying the most for specific procedures or supplies and/or has the most lenient utilization review policy. Several cases of manipulation or abuse have been documented by carriers and OI investigators.

Manipulation of Jurisdiction Rules

Use of 1-800 numbers typically involves a company in one state establishing a 1-800 number in another State for the sole purpose of obtaining a higher reimbursement from the other carrier and/or avoiding UR limits. For example, an Oklahoma supplier providing supplies to Oklahoma residents may find that California has a higher reimbursement rate per item. To get around the jurisdiction rules which state that the carrier for the jurisdiction where the order was taken is responsible for processing the claim (point of sale), the provider gets a 1-800 number in California. Instead of making a call to the Oklahoma supplier using a local number, beneficiaries are directed to use the 1-800 number. Since the point of sale is now California, the California carrier makes payment.

An example of DME jurisdiction abuse underscores a lack of carrier controls regarding a claim jurisdiction determination:

Jurisdiction Abuse: *A Case Example*

This case involves Medicare Carrier A. Carrier A did not recognize through its application process, that a company (Company A) seeking a number was essentially a billing entity and not a supplier. Company A had entered into a business arrangement with an ostomy supply company (Company B) operating in another state and carrier's jurisdiction. Company A agreed to buy all invoices for supplies sold and delivered from or at Company B. Company A pays Company B 125% of the face value of the retail price on the invoice. Company A then bills Carrier A for the supplies as if they had supplied them in the first place. Also, Company A is alleged to be fragmenting purchased supplies in order to maximize reimbursement. Both companies are now under investigation by the OIG.

The carrier's application process did not identify whether Company A was actually a supplier. Had the carrier scrutinized the company to a greater degree, the intentions of the supplier might have been discovered during the application process, rather than after significant overpayments had occurred.

Correct determination of claim jurisdiction may also be an issue with physicians. For example, the definition of a physician's office for purposes of determining the correct locality prevailing charge is vague when the physician provides services in multiple pricing localities with no clearly defined offices or an office which is primarily just a billing office.

Claim jurisdiction can be confusing and could be manipulated by providers unless carriers carefully scrutinize provider applications to determine the applicant's situation. Yet, most carrier applications do not request sufficient information from providers to test for unusual jurisdictional situations. Consequently, it is possible a carrier would not recognize an unusual situation and make an incorrect jurisdiction decision resulting in overpayments.

- Most carriers do not uniquely identify physician assistants and thus, cannot perform adequate utilization reviews.

Only five carriers assign provider numbers to PAs. Those not assigning PAs a unique identifier number do not have a means of conducting utilization review. Although carriers are required to develop charge profiles for PAs, PAs are not subject to the same UR monitoring activity on an individual basis except for a tangential review under the employing group or physician.

While relatively small, the number of PAs has increased the last few years at a rate of over 2,000 per year nationally. As of the beginning of this year, there were approximately 23,500 PAs.

Dependence on the supervising physician - PA relationship, the small number of PAs, and the requirement that PA services be billed by the physician may explain why many carriers have devised provider number assignment schemes which do not recognize the PA independently (PA given a separate provider number). Although many carriers do require or verify a PA's certification or license, 11 carriers do not. (See Appendix E for a description of some carrier methods for processing PA claims.)

While some carriers do not validate the credentials of a PA, several more do not determine if the physician billing the Medicare service is in fact the supervising physician pursuant to State registration requirements. An example of such registration requirements exist in Ohio. An Ohio PA is only allowed to practice as an employee and under the direction of a supervising physician or group of physicians. Further, PAs must be registered with the applicable State board. Section 4730.02(f) of the Ohio Revised Code states, "when the assistant ceases to be employed by the physician or physicians to whom his certificate of registration is issued, his registration is immediately suspended."

- Carrier computer records maintained on providers need improvement.

Especially in the case of computer matches with State medical boards to determine legal authorization to practice, certain carrier records must be entered accurately. Two fields are especially important - provider name and license number.

Provider name irregularities exist.

Review of carrier provider files at the three carriers visited revealed carriers enter the name as given by the provider on the application. For example, one provider might be listed as Robert Stanley Smith Jr. on his license, while the carrier might have entered the name as Bob Smith or R. Smith on the carrier's file. Additionally, we saw many providers with multiple provider numbers having different name variations for the same provider.

Another problem, noted by the Physician Registry, involves hyphenated names. Some carriers have entered hyphenated names in their computer system in a manner complicating

matching with the Registry. As an example, a carrier might submit records having hyphenated names where the first part of the hyphenated name is in the last name field while the rest of the name is in the suffix field. This makes computer matching of the name fields very difficult according to the Registry.

The situations mentioned above create unwarranted confusion not only for computer matching but for anyone reviewing provider records.

Provider license numbers are missing or inaccurately entered.

License numbers facilitate communication with licensing agencies concerning providers who have lost the legal authority to practice. Specifically, it is a crucial data element for computer or manual matching which might occur with data supplied by a State licensing agency or board.

While few carriers do not record provider license numbers in the provider's computer record, a considerable number of carriers have only recently begun this activity. Additionally, several carriers do not enter the license number for all types of providers. For example, 13 carriers do not enter the license number of an independent clinical psychologist. This compares to only two carriers not entering the license number of a doctor of medicine.

Even if the license number is entered, carriers may not be ensuring the accuracy of the number. To illustrate, in the three carrier provider files reviewed, we encountered error and inconsistency in the recording of license numbers. Transposing digits of the number was the most frequently encountered error. To a lesser extent, some license numbers were incomplete, had too many digits, or included inappropriate prefixes.

Many carriers assign additional provider numbers solely for a provider's bookkeeping convenience.

Several situations can allow a provider to legitimately have more than one provider number (or modifier to a base number). Carriers give a physician who practices in both a group and a solo practice a number for each. If a provider has a practice in more than one reasonable charge locality, carriers assign the provider different provider numbers or modifiers to an existing provider number for each of these localities.

However, a solo provider with the same specialty and practice in the same pay locality can have only one customary charge profile regardless of the number of offices maintained (MCM 5209). Some carriers interpret this to mean the solo provider may have only one provider number per pricing locality. To give the provider more provider numbers would perform only a bookkeeping purpose for the provider since payment would be the same if an additional provider number were given.

On the other hand, some carriers appear to have fewer limits on the number of provider numbers or modifiers given to a provider. For example, a physician with multiple office

settings in the same pricing locality could be given an additional provider number or a new modifier to a base number for each unique address. Also, if the payee or tax identification number under which payments are recorded is different, the carrier assigns different provider numbers.

As one carrier medical director stated, "it appears we are being asked to act as a bookkeeper by providing multiple provider numbers." One example cited by the director involves multiple provider numbers assigned to a radiologist "in order to segregate payments for his professional services as opposed to payments to the same radiologist for technical services where the equipment may be owned by a different entity." Several carriers reported that giving multiple provider numbers was just a "matter of courtesy to the provider." One carrier cited specific direction from its accounting department to "give multiple provider numbers for each physician practice location."

Figure 4 depicts the different carrier practices in assigning additional provider numbers (or modifiers to a base number) to the same provider. It also shows some carriers treat certain types of providers differently when assigning additional provider numbers for the bookkeeping purposes of the provider.

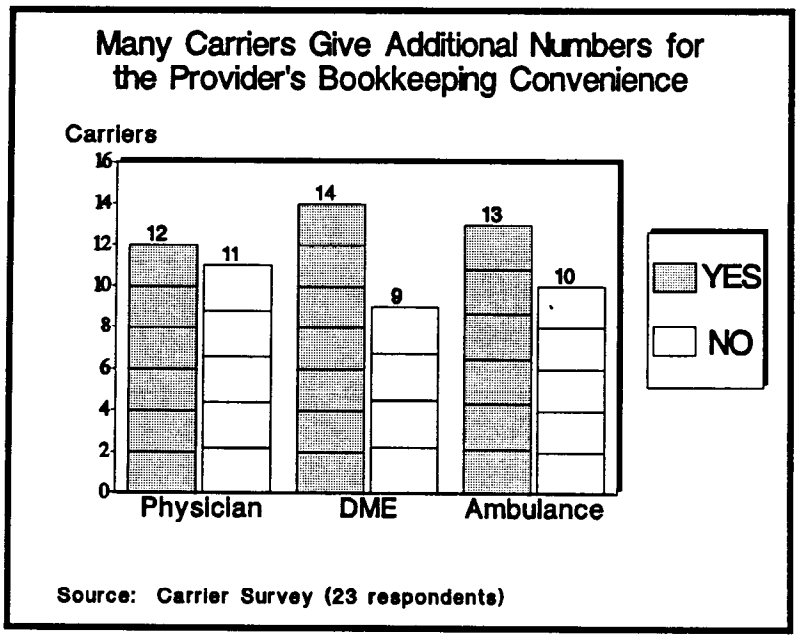


Figure 4

Data supplied HCFA by the Physician Registry confirms many physicians do have more than one provider number. (See Figure 5.) Over fifty percent of medical physicians (doctors of medicine or osteopathy) have multiple carrier records at the same or other carriers. The HCFA refers to such records as active practice settings.

Many Medical Physicians Have Multiple Provider Numbers with the Same or Multiple Carriers

Carrier Numbers/ Records	One Carrier		Two Carriers		Three Carriers		Four or More Carriers		Total	
1	197,618	46.3%	0	0.0%	0	0.0%	0	0.00%	197,618	46.3%
2	92,651	21.7%	28,739	6.7%	0	0.0%	0	0.00%	121,390	28.5%
3	36,561	8.6%	16,800	3.9%	1,331	0.3%	0	0.00%	54,692	12.8%
4	15,405	3.6%	8,483	2.0%	1,093	0.3%	75	0.02%	25,056	5.9%
5	7,248	1.7%	4,338	1.0%	631	0.1%	79	0.02%	12,296	2.9%
6–10	7,966	1.9%	5,028	1.2%	804	0.2%	145	0.03%	13,943	3.3%
11–46	788	0.2%	591	0.1%	92	0.0%	33	0.01%	1,504	0.4%
Total	358,237	84.0%	63,979	15.0%	3,951	0.9%	332	0.08%	426,499	100.0%

Source: Preliminary UPIN data presented by HCFA researchers at the 118th Annual Meeting of the American Public Health Association, October 1, 1990.

Figure 5

Variation exists from carrier to carrier concerning the average number of active records (practice settings) for physicians with UPINs. Carrier averages range from a low of 1.05 to as many as 2.49 provider numbers (practice settings) per physician. (See Appendix F.) While many factors such as the number of carrier pricing localities or local physician practice patterns may help to explain carrier variations, carrier ease of assigning multiple provider numbers is surely a significant factor.

Interestingly, we found three carriers with multi-state jurisdiction, and the States' averages were virtually identical. (See Figure 6.) This finding underscores the impact a carrier's provider number assignment policy can have on the average number of provider numbers per physician.

Carrier Policy Impacts Provider Numbers (Records)

Carrier	Jurisdiction	Avg. #s/records per Physician
Nationwide Mutual Insurance	Ohio	2.20
	West Virginia	2.35
Aetna Life and Casualty	Oklahoma	1.32
	New Mexico	1.32
Blue Cross and Blue Shield of Arkansas	Arkansas	2.14
	Louisiana	2.14

Figure 6

RECOMMENDATIONS

The HCFA should:

- specify a minimum framework for provider number assignment to be followed by all carriers. Within this framework carriers should be allowed flexibility for implementation. Additionally, this framework should recognize similarities and distinctions between types of providers. Some areas to address include:

  - the minimum essential data elements carriers are to maintain in their computer systems on providers,

  - other information deemed necessary or valuable for the carrier to obtain from providers during the provider number application process,

  - provider information to be validated and the method(s) of verification, and

  - carrier responsibility to:

    - maintain a list of all Part B provider types with corresponding Federal, State and local laws affecting legal authority to practice and the carrier's methods of verifying legal authority. Carriers should be required to maintain communication with appropriate agencies (e.g, licensing) adequate to understand and monitor changes in legal authorization requirements.

    - ensure, before issuing a provider number, adequate documentation on each provider number assignment including:

      1) a completed application (containing a penalty clause for making false statements) signed by the individual provider; the owner, if a business; or a company official, if a corporation,
      2) the method and contacts used to verify the provider's credentials,
      3) a list of all other provider numbers assigned the provider (the carrier should determine the need for continued use of identified numbers and document justification for the new number), and
      4) the specific reassignment exception(s) applicable as well as a statement, signed by the reassigning provider, acknowledging the reassignment.

- query the Registry, prior to assigning a provider number, for all active records/practice settings listed for the specified physician. The carrier should ascertain a provider's need for identified provider numbers and deactivate those not needed in their jurisdiction. The carrier should notify other carriers where numbers exist. Also, if an existing number is flagged for any type of carrier review, the new provider number should be considered for possible review as well.

- maintain relevant application documentation (e.g., application form) for active provider numbers.

- verify provider qualifications.

- have adequate system controls to 1) identify all provider numbers assigned to a particular provider and 2) ensure providers with multiple provider numbers cannot avoid prepayment review or screens, postpayment utilization review, and overpayment recovery.

- identify all providers (e.g., physician assistants) adequate for utilization review on an individual basis.

- update (at least) annually any listings used for license verification.

- identify the ownership of providers and maintain such information in the carrier's computer system in a manner ensuring identification of entities having the same owners. Carriers should review the ownership database for sanctioned individuals or entities.

- maintain provider records which are complete (e.g., license number entered in file) and consistent (e.g., name field should carry the same spelling in each record pertaining to the provider).

- evaluate their provider application forms to ensure they are well designed, easy to understand, and professional in appearance.

- ensure coordination between the provider number assignment staff and other departments (specifically, those for program integrity - medical and utilization review) for the sharing of experiences and suggestions for improvements to provider number assignment procedures.

- consider implementation of a system of user fees to defray the costs of provider number assignment and maintenance (e.g., determination of legal authorization to practice, Physician Registry contact for prior or present practices, more extensive review of applicants, assignment of additional provider numbers for a provider's convenience, and efforts to update records).

- expand the Physician Registry to include non-physician practitioners such as clinical psychologists, audiologists, nurse anesthetists, midwives, physical and occupational therapists, nurse practitioners, physician assistants, and clinical social workers.

- require the Physician Registry to provide feedback to carriers concerning all active practice records (settings) for physicians with unique practitioner identifier numbers.

- ensure carrier implementation of HCFA provider number assignment directives. We recommend HCFA consider evaluating implementation through a Contractor Performance Evaluation Program (CPEP) standard(s).

HCFA RESPONSE AND ACTION PLAN

The HCFA provided written comments on the draft report. More importantly, however, HCFA itself has undertaken several major initiatives to address these problems and related issues raised in a prior OIG report entitled "Carrier Maintenance of Medicare Provider Numbers." We and HCFA, therefore, worked together to reach agreement on an action plan to improve the provider number process. In light of this, we are no longer designating the problems cited in this and the prior report as a material weakness. The following is the agreed upon action plan:

MEDICARE PROVIDER NUMBERS

ACTION PLAN

GENERAL

HCFA will issue a modification to the Medicare Carrier Manual which will:

Clearly state that carriers have a responsibility to ensure the integrity of provider numbers and to ensure that only those practitioners and providers with legal authority to practice are given and may retain provider numbers.

Require carriers to stay abreast of changes in relevant laws and regulations concerning medical practice requirements.

Require carriers to make every reasonable effort to receive on an ongoing basis information from State licensing authorities and other appropriate bodies about the currency of licenses.

Require carriers to maintain provider number applications for at least six years after deactivation of the number (the period needed to facilitate

investigations, prosecutions, and sanctions). This requirement pertains to applications from both health professionals and provider entities which are discussed separately below.

Require carriers to periodically purge from their lists of approved numbers those that have been inactive and for professionals or entities who no longer have valid licenses required by the State.

HEALTH PROFESSIONALS

HCFA will continue to vigorously implement and enforce compliance with the provisions of the recently established UPIN system for Medicare physicians (which includes medical doctors, osteopaths, dentists, chiropractors, podiatrists, and optometrists).

HCFA will explore the extension of the UPIN system to cover all limited licensed professionals that can bill Medicare directly. HCFA will provide a schedule for doing so. This would include clinical psychologists, clinical social workers, and certified registered nurse anesthetists.

All registry data will be made readily available to all carriers on January 1. 1992. (Procedures prior to that date only allowed carriers to obtain information about professionals within their own jurisdiction.)

HCFA will monitor and ensure compliance of the carriers with their responsibilities regarding provider numbers as set forth in the Medicare Carrier Manual. (See *GENERAL* section above.)

SUPPLIERS

HCFA will implement a major reform of the carrier process for dealing with certain "suppliers". (Here, the term is meant to include entities which provide: durable medical equipment, routine and readily available supplies, prosthetics, orthotics, immunosuppressant drugs, and ESRD services.)

Some of the more important features of this initiative are:

Four regional carriers will be responsible for establishing supplier numbers and processing all Medicare claims for the above mentioned supplies.

A clearinghouse which will contain information from supplier number applications and whose data will be accessible to all of these carriers.

A standard application form which includes information to enable the carriers to identify each unique entity, their ownership, related entities, and sanctions.

The application form will contain a signed statement of the applicant attesting to the veracity of all information provided and acknowledging responsibility for false or misleading statements.

The carriers will be responsible for processing all claims for supplies furnished to beneficiaries who reside within their jurisdiction.

HCFA plans to implement this major reform within the next two years.

The statement of work for the contract under which these carriers will function will include a clear statement of responsibilities concerning supplier numbers similar to those listed in the *GENERAL* section above.

These carriers will be required to use the information in the clearinghouse to screen applicants for supplier numbers for such things as relationships to sanctioned individuals or business or to businesses suspected of fraud or abuse.

The carriers will verify the accuracy and completeness of the information contained in supplier number applications and files, and will identify and take appropriate action against problem suppliers.

HCFA will vigorously monitor compliance of these carriers with those contractual provisions related to the application for, granting of, and maintenance of supplier numbers. HCFA is determining how the performance of these carriers will be evaluated.

HCFA will require carriers to reenroll all suppliers every two years to insure that the ownership and operating information remains current.

In the future, HCFA will extend this system to cover other supplier entities such as independent physiological labs, magnetic resonance imagers, and ambulance companies. In the meantime, however, these other supplier entities will be required to use a standard application form with provisions for identifying ownership and sanctions, and including the signed veracity certification.

Endnotes

1

Only a few states monitor medical suppliers. One state, North Carolina, requires places dispensing prescription devices (e.g., TENS units, support hose, catheters) to register with the State Board of Pharmacy. An application must be completed before a permit is issued. The person issued the permit must supply such information as his education, home address, social security number, criminal history, employment history, and photo. New York is pursuing legislation to provide similar authority to its pharmacy board. Although the Board assigns permits, the Medicare carrier for North Carolina does not verify a supplier's permit prior to assigning provider numbers.

Another state, California, has passed legislation giving the Department of Health Services (Medi-Cal Program) the authority to require more involved information from suppliers of incontinent supplies (e.g., diapers). For example, suppliers must have a retail business location (not a P.O. Box) and inventory. Additionally, operators are required to supply such information as owners, interested parties and the driver's license numbers for names reported. Suppliers misrepresenting themselves through either the application or supporting documentation are subject to criminal penalties of up to 5 years in jail and as much as a $500,000 fine. A State official reports efforts to have the law amended to apply to other types of suppliers (e.g., durable medical equipment).

2

Suppliers such as DME often provide oxygen and other medical gases to beneficiaries. If the supplier repacks (transfills) the gases, they are required to register with the Food and Drug Administration (FDA). FDA conducts annual inspections of registered suppliers. Although it is a criminal offense not to register, FDA has not sought prosecution. Suppliers who do not register are not inspected and therefore, are not required to correct violations of FDA regulations nor stopped from providing gases if a danger to the public exists. None of the carriers contacted require FDA registration certificates from suppliers. In fact, no carrier's application form even asks the supplier whether they repack gases.

3

A new reassignment exception has been recently added. The exception allows physicians covering the practice of another physician to reassign payment to the absent physician for a specified period of time.

APPENDICES

Appendix A:	Part B Providers
Appendix B:	Carrier Respondents and State Jurisdictions
Appendix C:	Examples of Information Requested on Application Forms for DME and Physicians
Appendix D:	Claim Jurisdiction Rules Simplified
Appendix E:	Examples of Carrier Methods of Processing PA Claims
Appendix F:	Physician Registry Activity by Carrier
Appendix G:	Carrier Provider Number Assignment Activity
Appendix H:	Carrier Supplied Counts of Various Types of Providers
Appendix I:	HCFA Comments to the Draft Report

Part B Providers

Physicians

Doctors of Medicine	Doctors of Osteopathy	Dentists
Chiropractors	Optometrists	Podiatrists

Suppliers and Nonphysician Practitioners

Physician Assistants	Certified Nurse Anesthetists	Nurse Midwives
Clinical Psychologists	Audiologists	Physical Therapists*
Occupational Therapists*	Physiological Labs	Ambulance Companies
Clinical Social Workers	Nurse Practitioners	Independent Labs*
Ambulatory Surgery Cntrs*	Cardiac Rehabilitation Cntrs*	Diagnostic Testing Cntrs*
Durable Medical Equipment Suppliers		

** HCFA certifies*

Carrier Respondents and State Jurisdictions

# Assignment Questionnaire Respondents	Provider File Documentation	Carrier Name	State Jurisdiction Responsiblity	
*	*	Blue Cross and Blue Shield of Alabama	AL	Alabama
*	*	Aetna Life and Casualty	AZ, NV	Arizona, Nevada
*	*	Arkansas Blue Cross and Blue Shield, Inc.	AR,LA	Arkansas, Louisiana
*	*	Blue Shield of California	CA	California
*	*	Transamerica Occidental Life Insurance	CA	California
		Blue Cross and Blue Shield of Colorado	CO	Colorado
*	*	Travelers Insurance	CT	Connecticut
*	*	Blue Cross and Blue Shield of Florida, Inc.	FL	Florida
*	*	Aetna Life and Casualty	GA	Georgia
*	*	Aetna Life and Casualty	HI	Hawaii
*	*	Equicor	ID	Idaho
*	*	Health Care Service Corporation	IL	Illinois
	*	Associated Insurance	IN	Indiana
*	*	Blue Shield of Iowa	IA	Iowa
*	*	Blue Cross and Blue Shield of Kansas	KS	Kansas
*	*	Blue Cross and Blue Shield of Kentucky	KY	Kentucky
*	*	Blue Cross and Blue Shield of Maryland	MD	Maryland
*	*	Blue Cross and Blue Shield of Massachusetts	MA, ME VT,NH	Massachusetts, Maine, Vermont, New Hampshire
*	*	Blue Cross and Blue Shield of Michigan	MI	Michigan
*	*	General American Life	MO	Missouri
*	*	Blue Cross and Blue Shield of Kansas City	MO,KS	Missouri, Kansas (Johnson and Wyadotte Counties)
	*	Blue Cross and Blue Shield of Minnesota	MN	Minnesota
*	*	Travelers Insurance	MN	Minnesota
*	*	Travelers Insurance	MS	Mississippi
*	*	Blue Cross and Blue Shield of Montana, Inc	MT	Montana
*	*	Blue Shield of Western New York	NY	New York
*	*	Empire Blue Cross and Blue Shield	NY	New York
*	*	Group Health Incorporated	NY	New York
*		Equicor	NC	North Carolina
*	*	Blue Cross and Blue Shield of North Dakota	ND,SD**	North Dakota, South Dakota
*	*	Nationwide Mutual	OH,WV	Ohio, West Virginia
*	*	Aetna Life and Casualty	OK,NM	Oklahoma, New Mexico
*	*	Aetna Life and Casualty	OR,AK	Oregon, Alaska
*	*	Pennsylvania Blue Shield	PA,MD DC,NJ DE	Pennsylvania, Maryland (Prince Georges & Montgomery Counties) District of Columbia, New Jersey, Delaware
	*	Blue Cross and Blue Shield of Rhode Island	RI	Rhode Island
	*	Blue Cross and Blue Shield of South Carolina	SC	South Carolina
*	*	Blue Cross and Blue Shield of Texas, Inc	TX	Texas
*	*	Equicor	TN	Tennessee
*	*	Blue Cross and Blue Shield of Utah	UT	Utah
*	*	Travelers Insurance	VA	Virginia
*	*	Washington Physicians' Service	WA	Washington
*	*	Wisconsin Physicians' Service	WI	Wisconsin
*		Equicor	WY**	Wyoming
38	40			

*** Blue Cross and Blue Shield of North Dakota has assumed responsibility for Wyoming from Equicor.*

Information Requested on Application Forms for DME

Information Requested	Carriers Gathering Data Count	Percent
Background/Profile Information:		
Business Name	37	100%
Doing Business As (D/B/A)	1	3%
Billing Address	28	76%
Billing Telephone	18	49%
Business/Office Address	33	89%
Office Telephone	32	86%
County	4	11%
Tax number (SSN and/or EIN)	33	89%
Name as listed under your tax number	1	3%
(If SSN and EIN required) Which number should be used	3	8%
State business license number	4	11%
Contact person	1	3%
Name of person authorized to sign claim forms	3	8%
Request for Some Type of Documentation with Application:		
Copy of Business Articles of Incorporation	3	8%
Financial Statement for the last full year of operation	2	5%
Fictitious Name Statement	1	3%
Copy of Seller's Permit	2	5%
Commercial references from firms which the supplier is doing business	1	3%
DME supplier statement of responsibility	2	5%
Copy of W9 tax form (request for tax payer identification numbers and certification)	1	3%
Further clarification of charge structure if associated with another company	1	3%
Supplier is requested to provide retail price lists	1	3%
Certification and Signature on Application:		
Certification statement attesting to truthfulness	7	19%
Signature of person completing application	34	92%
Title of person signing application	15	41%
Date application completed	25	68%
Type of Business:		
Type of supplier and/or products sold	32	86%
Type of business (e.g, individually owned, partnership, corporation)	7	19%
Do you have a certified orthotist or prosthetist	1	3%
Under what circumstances will you be doing business in this state	1	3%
Prior Sanctions:		
Have employees or owners been the subject of legal action related to billing	1	3%
Questions Concerning What and How Services are Provided:		
Under what circumstances will you be doing business in this state	1	3%
Does the beneficiary sign contract prior to or at the time of delivery	1	3%
Does a contract indicate if the supply is rental or purchased	1	3%
Is the equipment provided both purchased and rental items or purchase only	1	3%
How are prescribing physicians' and beneficiaries' signatures obtained	2	5%
The names and addresses of parties supplying your DME equipment	1	3%
Do sales representatives always have direct onsite contact with beneficiary at sale	2	5%
Are sales made through catalogs (mailorder)	4	11%
Describe how items are marketed	3	8%
Describe how orders are received and processed (e.g., phone, mail, or in person)	4	11%
If testing is performed, what type is done and what physician provides training	1	3%
Ownership, Financial Interest, and Employee Questions:		
Owner's name	22	59%
List all licensed practitioners who are employees, owners or have a financial interest	3	8%
List all licensed practitioners who are consultants or contractors	3	8%
Number of employees	1	3%

Information Requested on Application Forms for DME (cont.)

Information Requested	Carriers Gathering Data Count	Percent
Billing Questions:		
Is a billing service used (provide the name and address)	6	16%
Will this office bill by electronic media claims	4	11%
Provide the location of billing records	2	5%
Is a hospital your billing agency	1	3%
Is this your central billing office	1	3%
Will you bill from your corporate or office address	1	3%
Are both Medicare and NonMedicare patients charged the same for the same services	1	3%
Will you be billing for patients located in other states	3	8%
Participation Status Questions:		
Have you participated in Medicare in the past	5	14%
Do you accept assignment (will participate)	2	5%
Questions to Determine Jurisdiction, Other Provider Numbers, and Service Area :		
Do you bill other State insurance companies	1	3%
Do you have other numbers with this carrier	5	14%
Do you currently have a Medicare billing number in other states	9	24%
Do you bill any of these numbers? If so, what items are billed at each	1	3%
Do owners/operators have any other numbers	2	5%
List all companies related to yours which are or have been Medicare providers	3	8%
Are there any similar companies in this State in which owners have a financial interest	3	8%
In what States have you been located and what numbers were used	2	5%
Do you have other satellite offices/locations in the State	13	35%
Are you part of a chain of stores with a centralized billing office	3	8%
If yes, should correspondence be sent to the billing office	1	3%
Is this company a chain store	1	3%
Is you company associated with any other supply company	1	3%
If yes, what is the number of sales outlets, names, and are charges uniform	1	3%
List all individuals having a financial interest in your company who have been in Medicare	2	5%
Do you have a branch office in this State	1	3%
Is your office a branch or main office	1	3%
Is you firm a branch office or multi-state supplier? If so, where are billing and tax records	1	3%
Do you have sales representatives in this state (give names, addresses and phone #s)	12	32%
What is the name of your parent company	2	5%
Are you hospital based	2	5%
Is a member of this entity currently employed by another state or out-of-state company in a management, accounting, auditing, or similar capacity	2	5%
Are you non-profit	1	3%
Questions Concerning the Supplier's Past:		
Date this business started (or first started providing services)	12	32%
Have you recently terminated your association with any supply company in this area	1	3%
Was this company purchased (give business name, previous owner and	1	3%
were accounts receivable purchased by you)	1	3%
Have you had a billing number in this area	2	5%

Source: Review of application forms used by 37 carriers.

Some Types of Information Obtained on Physician Application Forms

Information Requested	Carriers Gathering Data Count	Percent
Background/Profile Information:		
Physician's (provider's) Name	38	100%
Name Suffix	9	24%
Doing Business As (D/B/A)	5	13%
Billing Address	33	87%
Billing Telephone	15	39%
Business/Office Address and Telephone	38	100%
County	18	47%
Tax number (SSN and/or EIN)	38	100%
Which tax number should be used (SSN or EIN)	2	5%
Resident or Intern	27	71%
Date of Birth	38	100%
State Medical License Number	38	100%
Medical school and year of graduation	38	100%
Medical Specialty	38	100%
Subspecialty(s)	17	45%
Board Certification	35	92%
Board Certification Effective Date	3	8%
State License Issue date/effective date	16	42%
License expiration or renewal date	4	11%
Is the license temporary or permanent	4	11%
What is your UPIN number	0	0%
On the application form, a copy of the provider's State license is requested	4	11%
If license is temporary, the application form requests a copy of the temporary permit	1	3%
Certification and Signature on Application:		
Certification statement attesting to truthfulness	13	34%
Signature of person completing application	34	89%
Title of person signing application	3	8%
Application specifies that the physician must sign form	12	32%
Date application completed	33	87%
Type of Business:		
Type of practice (solo, group, etc.)	29	76%
Type of business (e.g. individually owned, partnership, corporation)	4	11%
Present or Past Sanctions or Overpayments:		
Currently owe Medicare an outstanding balance	1	3%
Ever been the subject of civil or criminal action (sanctioned)	3	8%
Practice Specifics:		
Date practice started	19	50%
List all other practice locations	11	29%
Previous practices	19	50%
Any provider numbers with this carrier	15	39%
Any provider numbers with other carriers	18	47%
Will a billing service be used	6	16%
Contact person	3	8%
Name of person authorized to sign claim forms	1	3%
The name and address of payee if different from provider	12	32%
Are you hospital–based or compensated	13	34%
Do you employ a physician assistant or nurse practitioner	1	3%
Do you provide services in a Health Manpower Shortage Area	7	18%

Source: Review of application forms used by 38 carriers to assign a provider number to a solo practice physician.

Claim Jurisdiction Rules Simplified

TYPE SERVICES	JURISDICTION DETERMINATION
Physician Services	
Services rendered from an office in a single pay locality	Carrier servicing office location
Services rendered from offices in more than one carrier's area	Each office serviced by appropriate carrier based on each office location
No office, uses home address	Home address location
Services provided by outside facility (e.g., clinic)	Location of outside facility
Provider facility bills for services of provider-based physician or physicians who renders services primarily in provider facility setting (e.g., services performed in a hospital setting, hospital bills)	Location of provider facility
Provider-based physician who maintains a private office for the treatment of his own patients	Private office location
Provider-based physician bills patients directly or through billing service yet does not have an office outside the provider facility	Location of provider facility
Provider-based physician performing services in more than one facility	Each provider facility location for services rendered therein

Note: Physicians who maintain more than one office cannot be required to bill from each office for the services rendered in the individual office.

Supplier Services

A single office supplier is a supplier with branch offices, sales/rentals outlets, or representatives in only one carrier jurisdiction. Multiple carrier suppliers are those suppliers with branch offices or sales/rental outlets in more than one carrier geographic area.

Single office supplier	Carrier servicing office location regardless of whether supplier provides services to customers outside the carrier's service area
Multiple-carrier supplier	Location of where the service is furnished to the beneficiary whether or not the supplier uses a central billing office (e.g., the site where the company met with the beneficiary or where the company received the beneficiary's call - where the service was furnished)
DME supplier with branch offices	Location of where purchase made or catalog sale or if no branch office or catalogue outlet, the location where the regional catalogue center is located and from which the equipment was shipped
Supplier of portable x-ray, EKG, or similar portable services	Location of where the service is rendered
Independent laboratory	Location of where the laboratory test is performed

Some Carrier Methods of Processing PA Claims

One carrier reviewed (BC/BS of Minnesota) assigns a provider number (e.g., P005) to physician assistants along with a group number to the clinic or group employing the PA. Those responsible for filing any claims are told to include the PA's number in item 24H of HCFA form 1500 to indicate the performing provider. The supervising physician's name is to be placed in item 24C and the name and provider number of the group or clinic is to be included in item 31.

Some carriers like Nationwide of Ohio, do not assign a number to a PA, but rather flag a supervising physician's number (e.g., Ohio uses flag 54) to indicate to the claims staff that the provider number department has verified that a licensed PA works for this provider. A carrier official said that claims should indicate who the PA is that did the service, but is not required for the claim to process. However, even if the PA is identified on the claim, a claim representative processing the claim could only ascertain from the computer that the supervising doc has a PA employed. Only the Flag indicator is accessible. Consequently, if a physician employed more than one PA or a new PA replaced the PA which was approved by the provider number department, the carrier would have no knowledge of what PA performed the service.

Like Nationwide, Aetna of Georgia does not assign a number to PAs. However the carrier does require the claim to indicate the physician assistant who's qualifications are verified at the time of claim processing. A claim representative is instructed to enter the first 4 characters of the physician assistant's name, the first initial of the first name, two spaces and the first three initials of the supervising doctor's name. If the physician assistant had been previously credentialed by the carrier (license or certification verified) the claim would process. However, if such a mnemonic check reveals the physician assistant has not been set up for this physician, the claim will suspend and an application will be sent to the submitter of the claim.

Carrier Registry (UPIN) Activity

Carrier Name	State	Total Records	UPINs Assigned	Average Records per UPIN
Railroad Retirement Board (N CNTL)	*	39,809	37,899	1.05
Travelers (Railroad Retirement Board)	*	53,461	47,983	1.11
BC/BS of Rhode Island	RI	3,292	2,879	1.14
Group Health Incorporated	NY	6,607	5,436	1.22
BC/BS of North Dakota	WY	950	776	1.22
Washington Physicians' Service	WA	13,607	10,500	1.30
BC/BS of Colorado	CO	8,647	6,622	1.31
Aetna Life and Casualty (b)	OK	8,161	6,205	1.32
Aetna Life and Casualty (b)	NM	4,130	3,135	1.32
Travelers	CT	13,356	9,827	1.36
Wisconsin Physicians' Service	WI	15,771	11,572	1.36
Aetna Life and Casualty (c)	HI	3,505	2,541	1.38
BC/BS of Montana	MT	2,623	1,896	1.38
Travelers	MN	10,537	7,512	1.40
BC/BS of Utah	UT	4,612	3,229	1.43
Aetna Life and Casualty (a)	AK	1,309	916	1.43
BC/BS of North Dakota	SD	4,619	3,165	1.46
BC/BS of Massachusetts (a)	ME	4,880	3,332	1.46
Travelers	VA	15,236	10,322	1.48
BC/BS of Pennsylvania (a)	NJ	26,152	17,713	1.48
Aetna Life and Casualty (e)	AZ	11,920	8,036	1.48
BC/BS of Kansas	KS	5,673	3,801	1.49
Aetna Life and Casualty (e)	NV	3,098	2,068	1.50
Blue Shield of Western New York	NY	19,931	13,232	1.51
BC/BS of Nebraska	NE	4,447	2,888	1.54
BC/BS of Massachusetts (a)	NH	4,331	2,796	1.55
Blue Shield of Iowa	IA	12,305	7,739	1.59
Equicor	ID	3,202	2,000	1.60
BC/BS of Pennsylvania (a)	DC	14,280	8,730	1.64
General American Life Insurance Co.	MO	15,431	9,418	1.64
Aetna Life and Casualty (d)	GA	18,322	10,753	1.70
Aetna Life and Casualty (a)	OR	12,030	6,990	1.72
BC/BS of Pennsylvania (a)	PA	57,551	32,931	1.75
BC/BS of Vermont	VT	3,382	1,934	1.75
Travelers	MS	7,570	4,298	1.76
BC/BS of Maryland	MD	18,600	10,539	1.76
BC/BS of Texas	TX	60,571	33,894	1.79
BC/BS of Kansas City	MO	7,352	4,085	1.80
Equicor (a)	TN	20,058	11,117	1.80
BC/BS of Michigan	MI	32,785	18,079	1.81
Associated Insurance Company	IN	20,455	11,104	1.84
Health Care Service Corporation	IL	52,320	28,397	1.84
BC/BS of Pennsylvania (a)	DE	2,637	1,409	1.87
BC/BS of Kentucky	KY	14,811	7,912	1.87
Empire BC/BS	NY	76,057	39,950	1.90
Transamerica Occidental Life Ins. Co.	CA	69,990	36,542	1.92
BC/BS of Massachusetts (a)	MA	47,909	24,749	1.94
California Blue Shield	CA	104,248	53,212	1.96
Equicor (a)	NC	28,867	13,983	2.06
BC/BS of Florida	FL	71,825	33,634	2.14
BC/BS of Arkansas (a)	AR	11,147	5,216	2.14
BC/BS of Arkansas (a)	LA	19,900	9,305	2.14
BC/BS of Alabama	AL	19,855	9,078	2.19
Nationwide Mutual Insurance Co. (a)	OH	52,459	23,808	2.20
BC/BS of Minnesota	MN	9,137	4,027	2.27
Nationwide Mutual Insurance Co. (a)	WV	10,016	4,255	2.35
BC/BS of South Carolina	SC	19,274	7,733	2.49
Total		1,205,010	703,102	1.71

– letters next to carrier names distinguishes between same carrier but different management control.

Source: From data supplied the OIG from the Physician Registry 12/90.

Provider Number Assignment Activity

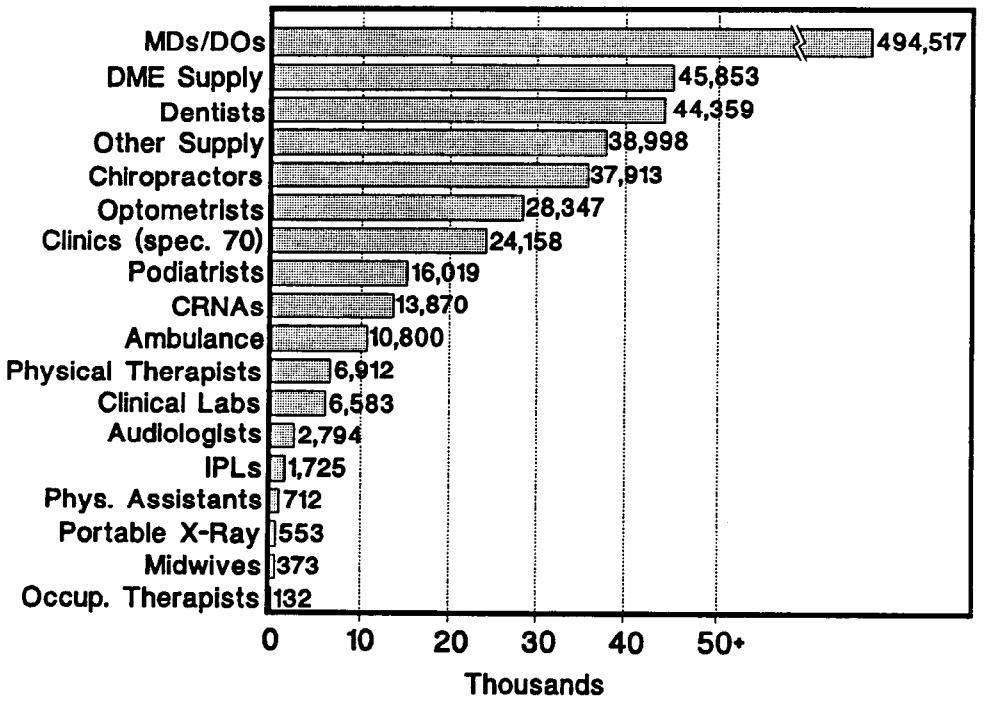
Carrier Name	State	Provider Numbers Issued or Cancelled Each Month		Average Time (days) to Process a Provider Number Request		Yearly # Request Rejections
		Issued	Cancelled	Physicians	DME	
Blue Cross and Blue Shield of Alabama	AL	200	<50	10	15	*
Aetna Life and Casualty	AZ, NV	50–75	<10	21	7–10	<10
Arkansas Blue Cross and Blue Shield	AR,LA	60	30	5	5	*
Blue Shield of California	CA	200+	25	14	14	*
Transamerica Occidental Life Insurance	CA	100	50	10	10	240
Travelers Insurance	CT	50	10	5	5	10
Blue Cross and Blue Shield of Florida	FL	500	100	10–15	5–10	20–25
Aetna Life and Casualty	GA	400	200	14	14	30
Aetna Life and Casualty	HI	51	20	10	5	5
Equicor	ID	30	10	5	5	1
Health Care Service Corporation	IL	450	50	14	14	100
Blue Shield of Iowa	IA	120–150	200	15	15	10–20
Blue Cross and Blue Shield of Kansas	KS	75	20	14	14	15
Blue Cross and Blue Shield of Kentucky	KY	75	5	15	15	10
Blue Cross and Blue Shield of Maryland	MD	70	30	10–15	10–15	125
Blue Cross and Blue Shield of Massachusetts	MA, ME VT,NH	70–100	10–15	5–7	5–7	*
Blue Cross and Blue Shield of Michigan	MI	180	211	10	10	*
General American Life	MO	75	10	30	30	30
Blue Cross and Blue Shield of Kansas City	MO,KS	70–75	10	2–10	2–10	*
Travelers Insurance	MN	150	20	3–5	3–5	Minimal
Travelers Insurance	MS	110	10	10	10	75
Blue Cross and Blue Shield of Montana	MT	33	5	15	15	10
Blue Shield of Western New York	NY	200	10–30	10	10	0
Empire Blue Cross and Blue Shield	NY	900	10	10	20	200
Group Health Incorporated	NY	20	20	10	10	*
Equicor	NC	600	50	20	20	2
Blue Cross and Blue Shield of N. Dakota	ND,SD	75+	<10	2	2	few
Nationwide Mutual	OH,WV	1430	75–100	70	70	500–1000
Aetna Life and Casualty	OK,NM	20	*	7	7	*
Aetna Life and Casualty	OR,AK	70	*	15–20	15–20	*
Pennsylvania Blue Shield	PA,MD DC,NJ DE	175 a	10 a	4	4	<25
Blue Cross and Blue Shield of Texas, Inc	TX	1098	354	30	30	315
Equicor	TN	300–400	10–50	30	30	10–20
Blue Cross and Blue Shield of Utah	UT	45	10	5	5	*
Travelers Insurance	VA	*	*	5	10	*
Washington Physicians Service	WA	130	20	5	5	15
Wisconsin Physicians Service	WI	100	25	7–10	7–10	*

a *This value refers to # assignment for Pennsylvannia only and to new providers from out–of–state.*

** Indicates the carrier did not know*

Source: Carrier supplied approximations (5/90)

Carrier Counts of Some Part B Providers



Source: Provider estimates supplied the OIG by carriers (10/89). Data represents total counts for 47 states and the District of Columbia. Data from which this chart was derived follow on the next several pages.

Carrier Physician Counts by Type and State

State & Carrier		MDs/DOs	Dentists	Podiatrists	Chiropractors	Optometrists	Clinics
AL B/B		8,537	1,809	76	384	435	60
AR B/B	*	3,585		46	301	269	252
CA BS		35,634	725	1,357	3,721	1,560	1,770
CA TO		21,771	6,194	1,590	3,550	3,089	1,245
CO B/B		7,410	1,794	143	762	384	131
CT Tra		12,195	659	413	501	486	239
DC B/B PA	*	5,234	128	124	101	126	78
DE B/B PA	*	1,352	14	34	58	55	34
FL B/B	*	26,787	5,576	752	1,720	1,093	699
GA Aet	*	15,405	369	245	928	718	1,081
HI Aet		2,200		20	125	123	
IA B/B	*	4,640	343	131	698	536	
ID B/B	*	1,210	18	28	165	74	
IL B/B	*	17,628	665	864	1,564	1,067	948
IN B/B		7,923	130	290	590	680	320
KS B/B		4,148	1,042	61	499	367	373
KS B/B KC	*	970	29	29	100	35	2
KY B/B		8,390	328	97	432	451	95
LA B/B AR	*	8,761	528	75	512	342	418
MA B/B	*	19,809	4,256	694	807	1,058	450
MD B/B		6,396	1,475	227	198	221	342
MD B/B PA	*	3,443	93	100	71	69	47
ME B/B MA	*	2,401	67	56	161	190	68
MI B/B	*	23,670	3,088	798	1,768	1,644	542
MN B/B		5,915	613	83	616	439	395
MN Tra		2,695	70	75	440	100	
MO B/B	*	2,829	62	57	342	177	4
MO GA		4,512	338	118	839	372	107
MS Tra		2,730	65	32	170	166	
MT B/B		1,845	91	28	184	184	
NE B/B KS		3,339	194	64	208	276	57
NC Equ TN	*	8,963	396	168	509	627	2,333
ND B/B	*	1,100	39	11	119	100	86
NH B/B MA	*	1,686	554	46	175	120	47
NJ B/B PA	*	14,028	456	743	1,508	729	482
NM Aet OK		2,832	86	75	266	156	22
NV Aet AZ	*	1,845	30	41	166	94	
NY B/B Emp	*	26,856	229	1,687	2,078	1,213	582
NY BS West		15,720	416	290	715	524	816
NY GHI	*	4,292	149	417	284	183	
OH NM	*	20,957	1,127	852	1,055	1,161	755
OR Aet		5,217	166		557		7
PA B/B	*	32,679	479	1,362	2,300	1,782	703
RI B/B	*	1,995	584	72	85	138	
SC B/B		3,596	1,272	57	391	337	3
SD B/B ND	*	880	92	14	159	105	73
TX B/B		43,916	4,350	638	1,925	1,869	3,935
TN Equ	*	6,732	486	105	385	516	2,603
UT B/B		3,438	79	98	210	137	4
VA Tra		4,797	144	151	236	302	
VT B/B MA		1,602	343	15	93	64	31
WA PS		9,556	344	213	1,141	680	1,468
WI PS		3,228	1,624	181	814	441	172
WV NM OH	*	4,455	133	61	128	213	196
WY Equ	*	783	18	15	99	70	83
Total		494,517	44,359	16,019	37,913	28,347	24,158

** The presence of an * indicates approximate number of unique providers.*
*No * indicates the approximate number of provider records (i.e., numbers).*

– Data supplied by carriers to the OIG (10/89). Data applies to 47 states and the District of Columbia.

– Blank cells indicate the carrier has no providers with the indicated specialty or no counts were provided.

– Clinics are providers listed under HCFA specialty '70' (multispecialty clinic).

Carrier Nonphysician Counts by Type and State

State & Carrier		Physician Assistants	Audiologists	Nurse Anesthetists	Nurse Midwives	Physical Therapists	Occupational Therapists
Al B/B			28	784	2	118	15
AR B/B	*	8	19	283	3	71	
CA BS			276	64		391	9
CA TO				120		606	
CO B/B			63	63		56	9
CT Tra			50	47		215	2
DC B/B PA	*	21	14	1	2	28	1
DE B/B PA	*	9	7		1	36	1
FL B/B	*		437	873		1,530	
GA Aet	*		33	117	14	136	
HI Aet			9	19	7	26	
IA B/B	*		10	213		34	2
ID Equ	*		5	74		35	3
IL B/B	*		55	253		68	4
IN B/B			60	180		40	
KS B/B		99	40	431		83	13
KS B/B KC	*		17	118			
KY B/B		25	16	187	1	155	7
LA B/B AR	*	33	25	1,406	3	127	
MA B/B	*		41	195		201	2
MD B/B			50			157	3
MD B/B PA	*	3	13		3	49	4
ME B/B MA	*		18	50		36	
MI B/B	*		365	1,313	1	98	
MN B/B			4	474		16	
MN Tra			5	175		20	
MO B/B	*		6	236		9	2
MO GA			20	125		39	2
MS Tra			6	46		16	
MT B/B			22	14		28	3
NE B/B KS		34	6	193		53	2
NC Equ TN	*	119	13	972		64	2
ND B/B	*		10	135		4	
NH B/B MA	*		20	64		48	5
NJ B/B PA	*		53	6	1	172	6
NM Aet OK			30	62	8	28	
NV Aet AZ	*		12	19	13	31	1
NY B/B	*		108	222	34	353	10
NY BS			62	85	30	252	4
NY GHI	*		25			84	2
OH NM	*		173	96	3	120	2
OR Aet			33	68	10	103	2
PA B/B	*	305	177	48	135	249	3
RI B/B	*		12	104		38	
SC B/B		8	21	112	19	94	
SD B/B ND	*		6	121		2	
TX B/B			111	2,368	81	225	7
TN Equ	*	48	23	761		41	1
UT B/B			33	124		73	2
VA Tra			10	45		51	1
VT B/B MA			11	12		28	
WA PS			67	208	2	284	
WI PS			36	143		44	
WV NM OH	*		27	10		27	
WY Equ	*		1	31		20	
Total		712	2,794	13,870	373	6,912	132

Carrier Nonphysician Counts by Type and State (cont.)

State & Carrier		Ambulance	Portable X–Ray	Clinical Labs	Physiological Labs	DME*	Other Supply* (e.g., drug)
Al B/B		162	2	81	21	595	1,200
AR B/B	*	238	5	47	2	726	553
CA BS		150	56	1,065	69	8,161	473
CA TO		499	43	594		1,247	3,009
CO B/B		171	6	57	5	1,592	
CT Tra		105	12	291		722	368
DC B/B PA	*	11		28	6	220	237
DE B/B PA	*	27		56	11	58	178
FL B/B	*	236	46	438	393	4,270	3,456
GA Aet	*	163	34	81		1,229	5
HI Aet		4	1	18		45	37
IA B/B	*	298	3	26	127	33	944
ID Equ	*	102	1	17		182	126
IL B/B	*	473	22	196	69	1,346	1,646
IN B/B		290	12	135	120	1,637	
KS B/B		227	1	188		701	1
KS B/B KC	*	6	1	5		135	53
KY B/B		262	10	78	13	1,272	949
LA B/B AR	*	158	11	82	10	1,055	438
MA B/B	*	301	11	175	113	2,231	1,991
MD B/B		191	16	78		815	314
MD B/B PA	*	6	4	45	7	47	273
ME B/B MA	*	160	4	20	16	292	252
MI B/B	*	554	23	396		577	
MN B/B		222		47			1,316
MN Tra		50	1	15		151	220
MO B/B	*	70	3		38	322	184
MO GA		151	4	54	46	0	931
MS Tra		48	2	47	87	246	332
MT B/B		142		9		385	234
NE B/B KS		241	2	18		1,196	2
NC Equ TN	*	136	6	125	14	358	1,914
ND B/B	*	149		16		167	7
NH B/B MA	*	93	1	26	4	257	185
NJ B/B PA	*	74	17	113	29	579	1,876
NM Aet OK		97	2	39		253	192
NV Aet AZ	*	20	2	22		190	
NY B/B	*	714	68	172		1,251	714
NY BS		85	10	78	88	950	642
NY GHI	*	7	10	23	88	767	
OH NM	*	366	17	214		2,619	1,215
OR Aet		43	4	103		251	338
PA B/B	*	1,127	23	304	144	160	4,558
RI B/B	*	21	3	37		216	
SC B/B		82	2	41	1	624	861
SD B/B ND	*	162		24		181	365
TX B/B		796	25	385	99	3280	983
TN Equ	*	116	5	202	92	186	1,785
UT B/B		68	2	18		446	
VA Tra		84	8	34	13	211	843
VT B/B MA		69		4		129	136
WA PS		177		107		515	1,039
WI PS		381	8	24		249	1,251
WV NM OH	*	152	4	58		494	243
WY Equ	*	63		27		32	129
Total		10,800	553	6,583	1,725	45,853	38,998

** Other Supply consists of counts supplied by carriers under HCFA specialty code 87. DME consists of counts supplied under HCFA specialty codes 51–58. During the course of contacting some carriers, we discovered some carriers include DME under specialty 87 rather than specialty 54 as prescribed by HCFA.*